

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05514

05520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)				First	Middle	Last	20. DATE OF DEATH Month Day Year	2b. HOUR			
Mildred				Louise	Boulter	April 11 1969	2:50PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		December 16, 1913		55 yrs.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.				Kent					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown, Md.			Kent & Queen Anne's Hosp			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Kent		Rock Hall							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Edward Joseph Watson						Mary		Clara		Kendall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		16c. INFORMANT		Address					
No		220-07-3964		Robert M. Boulter--Rock Hall, Md.							
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death 1 yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Intestinal obstruction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
3-17-69		Obstruction			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 6</u> , 1969, to <u>April 11, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 11</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<u>Arthur T. Keefe, Jr., M. D.</u>		4-13-69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Arthur T. Keefe, Jr., M. D.		Chestertown, Md. 21620									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 14		Wesley Chapel		Rock Hall, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Alyce R. Lane		Church Hill, Md.		APR 17 1969		Charles Judge					

On 11/11/1997 at 11:11 AM

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05515

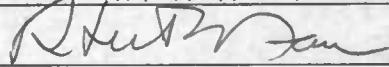
Est.

CERTIFICATE OF DEATH

05521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Edmund				R.	Cook	April 27	Day	1969	5 P M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
Male		White		May, 12, 1904			64 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
N.J.		U.S.A.					Kent.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chesterville				---			Farmer			Dairy		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Kent		Chesterville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		----			
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
James				Edmund	Cook		Margaret					Ricker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)				16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No.				150-12-5280			Mrs. Muriel P. Cook, Kennedyville, Md. 21645					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Had viral myocarditis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Fall, 1962, to 4/27, 1969, that (I) (we) last saw the deceased alive on 4/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 				DEGREE		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4-29-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Chestertown, Md. 21620								
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE 4/30/69		23c. NAME OF CEMETERY OR CREMATORIAL Sudlersville Cemetery			23d. LOCATION (City or Town) Sudlersville, Q.A. Md.		(County)		(State)	
24. FUNERAL DIRECTOR Edward Fellows & Son,				ADDRESS Millington, Md. 21651			25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE 			

13220

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05516

1. DECEASED-NAME (Type or Print)			First Ronald	Middle Eugene	Last Elliott	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 4	Day 30	Year 69	2b. HOUR 4 PM	
3. SEX male	4. RACE Col.	S. DATE OF BIRTH 12/20/1952	6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month 4	Doy 30	Year 69	2d. HOUR 4:45 PM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent					
10. CITY OR TOWN OF DEATH Millington (rural)			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesterville Forest			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Janitor at school			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Queen Anne		13d. INSIDE CITY LIMITS? NO		13e. STREET AND NUMBER Route one					
14. FATHER'S NAME Albert			15. MOTHER'S MAIDEN NAME Elliott			16. ADDRESS Leah Wiggins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 214 60 7779			17. INFORMANT Albert Elliott, Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of throat with hemorrhage Approximate Interval Between Onset and Death 965X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF and asphyxia Instantaneous (c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR XX 4/30 1969 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Gun shot wound					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Chesterville Forest			21f. LOCATION Street or R.F.D. No. Rural Millington			City or Town Kent	County Md.	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> Possible											
ACTUAL SIGNATURE <i>Albert W. Farr</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 5/3/69			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		23a. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery			23d. LOCATION (City or Town) Millington			(County) Kent	(State) Md.		
23b. DATE 5/3/69		23c. ADDRESS			23d. LOCATION (City or Town) Millington			(County) Kent	(State) Md.		
24. FUNERAL DIRECTOR <i>Kenneth Walley</i>		25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge						
		ADDRESS Kenneth Walley Chestertown, Md.			DATE 6 1969						

1900-1901

19. *Scutellaria* *lanceolata* *var.* *lanceolata* (L.) Benth.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05523

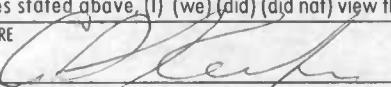
05517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Sadie	Middle Fitzgerald	Lost	2a. DATE OF DEATH Month April	2b. HOUR Year 1969 4:30 M
3. SEX Female	4. RACE Negro	S. DATE OF BIRTH Oct. 26, 1890	6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Marydel, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent	Md.
10. CITY OR TOWN OF DEATH Millington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ---	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER ----	
14. FATHER'S NAME Perry	First Middle Henry	Lost Kilson	15. MOTHER'S MAIDEN NAME Annie	Middle Lost Schribner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-54-5059	17. INFORMANT Niece. Rosa Martin,	Address Millington, Md. 21651		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> 402X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 7 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>you 12-</u> , 19 <u>62</u> , to <u>Apr 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>Apr. 27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Geza Koralewski M.D.</u>	DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 4.30. 1969	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Millington, Md. 21651				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	23b. DATE May, 3, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery.	23d. LOCATION (City or Town) Marydel,	(County) Caroline,	(State) Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,	ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR MAY 2 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

CS270

1. DECEASED-NAME (Type or print)			First Karen	Middle Lynette	Last Graves	2a. DATE OF DEATH April 14 1969	2b. HOUR 1:20 AM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Feb 12, 1960		6. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED WIDOWED		9. COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Chesertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chesertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME Charles		Middle Henry	Lost Graves	15. MOTHER'S MAIDEN NAME Hilda		Middle Virginia	Last Lively	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT		Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>2825 IMMEDIATE CAUSE (a) <u>Post-operative Complications</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) <u>due to Sickle Cell Anemia</u> BETWEEN ONSET AND DEATH last. (c) <u> </u> <u>1 week</u></p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. DATE OF OPERATION 4 5 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis & Lithiasis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1969</u> to <u>April 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 14 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 4. 14. 69		
22d. PHYSICIAN'S NAME (Type) ARTHUR F. KEEFE		22e. ADDRESS Chesertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/1969		23c. NAME OF CEMETERY OR CREMATORIY JANES CEMETERY		23d. LOCATION (City or Town) Chesertown Kent. MD		
24. FUNERAL DIRECTOR Genneth Walker		ADDRESS Chesertown, MD		25a. RECORD BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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AS229

1

FOR STATE
HEALTH DEPT.

05525 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05519

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3 & 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal.

1. DECEASED-NAME (Type or Print)	First John	Middle WESSEY	Last JOHNSON	2a. DATE KNOWN OF ESTI. DEATH MATED	Month Apr	Day 15	Year 1969	2b. HOUR 8:45 AM			
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH Dec 18-1898	6. AGE (in years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month Apr	Day 15	Year 1969	2d. HOUR 8:45 AM
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent								
10. CITY OR TOWN OF DEATH Chesterstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anna			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMING			12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Still Pond	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER —							
14. FATHER'S NAME Maxwell	First Johnson	Middle John	Last Johnson	15. MOTHER'S MAIDEN NAME Margaret Redding	First Margaret	Middle Redding	Last Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) —	17. INFORMANT ADDRESS Hospital Reindeer Chesterston Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1619</u> Hemorrhage from trachea				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Metastatic C25-C11-01722</u> DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Carcinoma of 13547X</u> DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED		
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Robert W. Farr</u>		EXAMINER'S NAME (Type) ROBERT W. FARR		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/15/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
23b. DATE 4-19-69		23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION CEMTY		23d. LOCATION (City or Town) STILL POND		(County) KENT		(State) MD.			
24. FUNERAL DIRECTOR VICTOR N. KENNEDY		ADDRESS STILL POND, MD.		25a. REC'D BY REGISTRAR APR 17 1969		25b. FILER'S SIGNATURE Robert W. Farr					

4
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05520

1. DECEASED-NAME (Type or Print)	First Melville	Middle xx	Lost Sewell	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4 23 69 19 10 15 M
3. SEX Male	4. RACE White	S. DATE OF BIRTH April 10, 1903	6. AGE (in years last birthday) 66 yrs	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Kent
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Q.A. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER xxx
14. FATHER'S NAME Marion	First Middle Sewell	Lost	15. MOTHER'S MAIDEN NAME Annie	Middle Lost Besowski
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-26-4997	17. INFORMANT Melville L. Sewell-Grasonville, Md.	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4124 2 or 3 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. hours				
DUE TO, OR AS A CONSEQUENCE OF <u>Manner of death resembled</u> (b) <u>cerebral hemorrhage or thrombosis</u>				
DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Robert W. Farr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Chestertown, Md.</u>		
EXAMINER'S NAME (Type) Robert W. Farr		22b. DATE SIGNED 4/25/69		
23a. BURIAL, CREMATION, REBURNED		23b. DATE April 26	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel	23d. LOCATION (City or Town) (County) (State) Rock Hall Kent Maryland
24. FUNERAL DIRECTOR Alyce R. Lane		ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR APR 29 1969
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Ladd</u>

35000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05527

05521

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
		NELLIE McWHORTER STERLING			Apr. 13, 1969	Month Day	2:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
female		white		July 19, 1889		79 yrs.		MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
USA		USA				Kent			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Washington Ave.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Kent		Chestertown				Washington Ave.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George McWhorter					Alice Stanton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
no		214 32 7167		Alice Marian Sidwell		Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: <u>Arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL IMMEDIATE CAUSE (a) <u>4124</u> BETWEEN ONSET AND DEATH years									
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.									
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19, 1967</u> to <u>4/13, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert W. Farr</u>		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>4/13/69</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Robert W. Farr		Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)	(State)
Burial		4/15/69		Chester Cem.		Chestertown, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
J. Willis Wells		Chestertown, Md.		APR 16 1969		Charles Judge			

75268

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05522

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Newton	Middle Casper	Last Taitt	20. DATE OF DEATH Month April	1 Day	Year 1969	2b. HOUR 6:30 P.M.
3. SEX Male	4. RACE White	S. DATE OF BIRTH 2/20/97			6. AGE (In years last birthday) 72	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent			Md.
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Car. Inspector (Ret.)			12b. KIND OF BUSINESS OR INDUSTRY P.R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box 158			
14. FATHER'S NAME Medford	First ?	Middle Taitt	Last	15. MOTHER'S MAIDEN NAME Nettie	First ?	Middle Hubbard	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 222-07-3202 A	17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asthma and/or cardiovascular disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) <i>Scalpitis</i>							
MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> , 19 <u>69</u> , to <u>4-1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A.C. Dick M.D.</i>		22c. DATE SIGNED <u>4-1-69</u>					
22d. PHYSICIAN'S NAME (Type)	23. DATE April, 5, 1969		23c. NAME OF CEMETERY OR CREMATORIUM Sudlersville Cemetery	23d. LOCATION (City or Town) Sudlersville, Q.A.C.O.; Md.	(County)	(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23e. ADDRESS Edward Fellows & Son, Millington, Md. 21651			25a. REC'D. BY REGISTRAR APR 7 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
24. FUNERAL DIRECTOR Edward Fellows & Son,	ADDRESS Millington, Md. 21651			DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05523

1

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
James Eckley Walker, Jr.					April	13	1969	3:10 P.M.	
3. SEX		4. RACE	S. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White	July 23, 1894		74	YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Phila. Pa. United States				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		KENT Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Chester Town		KENT and Queen Anne's Hosp. Restaurant owner		Restaurant owner		Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		KENT Co. Chester Town		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Box 225 E Chesapeake Estate			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
James				Walker, Sr.	? Mary				Butterworth
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		WW 1 216 32 9504		Hospital Records		Chester Town Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebrovascular accident 23 days							
4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),		DUE TO, OR AS A CONSEQUENCE OF a stroke							
stating the underlying cause (b),		DUE TO, OR AS A CONSEQUENCE OF a stroke							
lost.		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-21, 1969, to 4-13, 1969, that (I) (we) last saw the deceased alive on 4-13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		@C. Dick		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		A.C. Dick		22e. ADDRESS		4-13-69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)
Burial		4/16/69		Oak Lawn Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Wilho Wells		Chestertown, Md.		APR 16 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05530

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05524

1. DECEASED-NAME (Type or print)	First Katie	Middle Smith	Last Wallis	2a. DATE OF DEATH Month April	Day 30	Year 1969	2b. HOUR P 9:00 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 12-10-1877		6. AGE (In years last birthday) 91		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Defense Plant (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Queen Anne's Crumpton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME Walter	First Granville	Middle Wallis	Last	15. MOTHER'S MAIDEN NAME Anna	First Elizabeth	Middle Harrison	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 220-16-9964		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia rated - Roxbury, Md.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Deputy Medical Examiner for Kent County</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years 72 hrs.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fracture neck femur</i>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION 4-14-69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture neck femur</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> FOR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR <input type="checkbox"/> Month Day Year 300 P.M. 4 12 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Wife cooking supper pt. stepped back & fell to the floor.</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 12, 1969</u> to <u>Apr 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>Apr 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A. C. Dick M.D.</i>		22c. DEGREE M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5-1-69		
22d. PHYSICIAN'S NAME (Type) A. C. Dick M.D.	22e. ADDRESS Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/4/69	23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery	23d. LOCATION (City or Town) Crumpton, Q.A.	(County) Md.	(State) Md.			
24. FUNERAL DIRECTOR Edward Fellows & Son,	ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR MAY 7 1969	25b. REGISTRAR'S SIGNATURE <i>Stanley J. Judge</i>					

DATE ISSUED: 30/01/2017 BY: 11330 00133000

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 8 P.M.					
Mildred				C.	Younger	April 5 1969	Month	Day	Year						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.		
Female		White		July 22, 1917			51 YRS.								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		Kent and Q.A.		Factory worker			Cannery								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
Maryland		Kent		Rock Hall			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		xxx						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last					
Alvin		L.	Shreck		Mary			Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			Address								
583X		220-03-5949		Mrs. Alvin Shreck--Rock Hall, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Acute coronary insufficiency										½ hour					
DUE TO, OR AS A CONSEQUENCE OF (b)															
Chronic hypertensive disease										several					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(c) glomerulo nephritis										years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1968, to April 5, 1969, that (I) (we) last saw the deceased alive on 4/5 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYS.			MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 4/8/69			
Robert W. Farr															
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
		Chestertown, Maryland													
23a. BURIAL, CREMATION REMAINS		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)			(County)		(State)			
Burial		April 9		St. Johns			Rock Hall,			Rock Hall,		Maryland			
24. FUNERAL DIRECTOR		ADDRESS						25a. REC'D BY REGISTRAR		25b. FUNERAL DIRECTOR'S SIGNATURE					
Alyce R. Lane		Church Hill, Md.						APR 11 1969		Charles Judge					

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